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## ORIGINAL ARTICLES.

### THE RELATION OF SEX TO LONGEVITY.

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The consideration of those elements in the individual which influence the duration of life, while not recognized in that narrow view of the physician's calling which looks upon him merely as a healer of the sick, is yet an essential part of his broader and more important work, the physical improvement of the race. No apology is therefore needed for calling the attention of the readers of the REPORTER to a branch of this subject, in the hope that it may prove to be of general interest, since the desire for long life is universal.

Some of these elements, such as residence, occupation, diet, and habits of life, are in a greater or less degree under the control of the individual, and capable of being modified by his intelligent coöperation. Others are wholly removed from such control, were determined before his birth, and are incapable of change. In this class, the element of sex fills an important part.

An investigation of this subject calls for a consideration of the following points: First, as to the facts. To what extent does the average duration of life differ for males and females? How does the mortality of the two sexes compare, both as a whole, and at different periods of life? In what proportion of cases do males and females reach advanced life, and which most frequently attains the extreme limit of longevity?

Next, as to conclusions. Wherein do these differences originate? How far are they due to certain peculiarities inherent in the sexual constitution? How far to the physiological and pathological results of sexual activity, and how far to external conditions incidental but not essential to the one sex rather than the other?

Let us consider first the comparative duration of life in males and females. According to the English Life Tables of Dr. Farr, which are based upon the experience of the total population of England and Wales for a long period of years, the expectation of life at birth of males is 39.91 years, and of females, 41.85 years; at ten years of age the expectation of males is 47.05 years, and of females, 47.67 years; at thirty, of males, 32.76 years, and of females, 33.81 years; at fifty, of males, 19.54 years, and of females, 20.75 years; at seventy, of males, 8.45 years, and of females, 9.02 years; and in general it may be

stated that the expectation of females is slightly greater than that of males at all ages. This conclusion agrees with that of observers generally, whenever the whole population is considered, but differs materially from the results of those life insurance companies which insure both sexes. This is shown by the American experience tables, compiled from the experience of thirty American companies. These show a less expectation for females than for males, in all but nineteen years, during which period it is either equal, or slightly greater for females. "This," says Actuary O. B. Ireland, an acknowledged expert in insurance statistics, "is presumably because the classes of women whose lives are offered for insurance are not, sanitarily, a fair average of the population; and because of the greater difficulty of getting a medical examination that shall truly discriminate."

Secondly, let us examine the comparative mortality of the sexes, both as a whole and at different periods of life.

The United States Census for 1880 gives the average death-rate for males as 15.35, and for females, 14.81.

The Massachusetts Registration Reports show that the average annual death-rate in that state for the six census years, 1860, 1865, 1870, 1875, 1880 and 1885 was 20.4 per 1000 for males, and 19.4 for females.

Certain of the fraternal benefit orders which insure both sexes, give as the result of their experience, conclusions slightly at variance with that of the thirty American life companies already quoted. Thus, the order of Chosen Friends has 37,644 members, of whom 11,732 are females. Their death-rate for fourteen years, averages 10.60 per 1000 for males, and 8.15 per 1000 for females. The Knights and Ladies of Honor have more female than male members. In a report for fifteen years, they say females as a class are still proving to be better risks than males. The death-rate each year, without exception, among the former has been less than that among the latter. The American Legion of Honor also reports a balance in favor of females.

Dr. Farr's English Life Tables show a mortality at all ages combined of 23.3 per 1000 for males, and 21.5 for females. This proportion does not hold good, however, for each of the different periods of life; for from ten to thirty-five the mortality is greater for females, while at all other ages that of males is greatly in excess. This shows plainly the unfavorable effect of approaching puberty and the early years of child-bearing upon the mortality of females. Dr. Block gives tables compiled from the vital statistics of eleven different countries of Europe, in which the average results correspond very nearly with those above given, although in some particular cases they differ materially.

Another table given by Dr. Farr shows that out of every 1,000,000 persons born, 511,745 are males and 488,255 females; being an excess of 4.81 per cent. of males. Of these, there die during the first year of life 83,719 males and 65,744 females, leaving at one year of age an excess of 1.31 per cent. of males; and in the succeeding years the numbers dying of each sex are such as to leave at eight years of age an excess of 1 per cent. of males; at fifteen an excess of 1.18 per cent. of males; at thirty-seven, of 2.08 per cent.; at fifty, of .93 per cent.; while at fifty-three, there is an equal number of males and females; at seventy, an excess of 8 per cent. of females; at eighty, of 19 per cent.; and at ninety, of 41 per cent. of females.

A table given in the Massachusetts Registration Report for 1890, compiled from a total of 869,694 deaths in that State for a period of twenty-six years, shows that from birth to ten years of age the male death-rate is in excess, from ten to forty that of females is in excess, from forty to fifty they are about equal, from fifty to seventy the male death-rate is again in excess, and after seventy a larger actual number of females die, though a less proportion of the number living at that age.

A comparison of these different tables enables us to formulate the following general conclusions, subject to local and temporary variations:

1. From birth to puberty, the death-rate is higher among males.

2. From puberty to the menopause, females have a higher death-rate than males.

3. From the age of the menopause in women to the end of life, the death-rate is higher among males, although after the age of seventy the actual number of female deaths is greater, as more have survived to reach that age.

4. The total mortality at all ages combined is slightly greater among males.

Thirdly, we come to the consideration of the next point at issue, namely, the proportion of males and females reaching old age, and also the extreme limits of advanced life.

In New York City, out of 27,003 deaths, 111 were of persons over ninety years of age, and of these seventy-seven were females and thirty-four males.

In Massachusetts, out of a total of 391,484 deaths from 1880 to 1890, there were 203 at the reported age of 100 years or over, and of these 153 were males and only fifty females. Eight out the 203 centenarians had reached the age of 110, and of these six were females and two males; and the oldest of all was a female, who had reached the great age of 118 years.

The *London Morning Post* finds that 1151 cases of octogenarians were reported in its columns in a single year, and of these 646 were females and 545 males. Above the age of eighty the proportion of females rapidly increases, so that at the age of 100 there are five times as many women as men.

Dr. Farr's English Life Table, No. 3, states that out of males living at twenty, one in three reaches seventy, one in eight reaches eighty, and one in seventy reaches ninety; while of females living at twenty, one in two and two-fifths reaches seventy, one in six and three-fourths reaches eighty, and one in forty-nine reaches ninety.

Hufeland, in his "Art of Prolonging Life," lays down the diction that "more women than men become old, but men only attain to the utmost limits of longevity." The first part of this law seems to be amply sustained by the figures we have given; as to the second part, the indications are opposed to his conclusions. It is no doubt true, however, that the larger proportion of historic instances of extreme longevity—*i. e.*, reaching 150 years or more—are of males; but it is also true that but very few, if any, of these cases can be considered as well authenticated.

The investigations of Prof. Cæsar Lombroso and William Ferrero, as detailed in their recent work, "The Female Offender," while not coming under either of the divisions we have adopted, are yet pertinent to the question as a whole. "Women," they conclude, "are not longer-lived than men, but have greater powers of resistance to misfortune and deep grief. This is a well-known law, which, in the case of the female criminal, seems almost exaggerated, so remarkable is her longevity and the toughness with which she endures the hardships, even the prolonged hardships of prison life. It is a well-known fact that the number of aged female criminals surpasses the male contingent. Some denizens of female prisons have reached the age of ninety, having lived within those walls since they were twenty-nine. Between 1870 and 1879, the inhabitants of prisons and convict establishments in Italy who were over sixty years of age showed a percentage of 4.3 among the women, and 3.2 among the men. Over forty years of age the proportion of females is greater; under forty, of males. These figures show how many more female offenders reach advanced ages than males, and prove also how the women stand punishment better. For among male criminals the number condemned to the galleys for life, or for longer periods of time than ten years, is far greater than among women."

It remains to consider the causes which lead to an increased death-rate of one sex rather than the other, modify the mortality-rate of each at different periods of life, and result in the slightly greater average longevity of females.

The strongest argument in favor of an original and fundamental difference of constitution and vitality due to the element of sex *per se*, is found in the greatly increased death-rate of males at both extremes of life. In early infancy especially, when it cannot be supposed that they are any less well cared for, or suffer from a more unfavorable environment in any direction than females, it is found that males die in so much greater proportion than females that the excess of nearly five per cent. of males

at birth is reduced to less than one and one-third per cent. at the end of the first year, and still further at the end of five years. As old age comes on, the difference in the environment of the sexes disappears, the conditions of childhood recur in a measure, and the male death-rate is again largely in excess.

Another proof of the same fact is found in the greater tenacity of life on the part of the female members of the criminal classes. This is shown under unfavorable environment, and conclusively proves her to possess greater innate endurance than do the male members of the same classes.

The increased mortality of females from puberty to the menopause is manifestly due to the sexual organization and functions. It is not, however, due entirely to either the physiological or pathological results of child-bearing, as it exists to some extent in all classes of females, whether virgin or married, fruitful or barren. Furthermore, it begins at the first approach of puberty, and is but slightly manifest during the menopause or the years immediately preceding it.

Much is no doubt due to the environment of the sexes, which differs greatly during all the years between childhood and old age. Throughout the whole of this period, women in the main lead lives more favorable to longevity than men. They are less robust, and oftener under the doctor's care; but their illnesses are largely functional in their nature and of a kind not likely to prove fatal. They lead more quiet and regular lives than men, are less inclined to indulge in dissipation and excesses, and have fewer bad habits to sap their vitality. Especially do they suffer less from the effects of alcoholic intemperance. They do not, as a rule, engage in any single hazardous employment, such as those connected with railroading, electric power and lighting, mining, and the more dangerous branches of manufacturing. So, too, they are excluded from the army, the navy, and the merchant marine service. They are, therefore, less exposed to death from accident or violence. Neither do they suffer in an equal degree with men from atmospheric vicissitudes.

On the other hand, women suffer more than men from impure air, faulty modes of dress, confinement in-doors, and lack of proper exercise; and hence suffer more frequently from certain forms of disease, notably pulmonary consumption, disorders of digestion, and maladies of the reproductive organs.

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RAGGED HAGGARD (*at the door*).—"I'm willin' to work, maddim, but I can't get nuthin' to do at my perfession."

MRS. SNAPPERTON.—"H'm! What is your profession?"

RAGGED HAGGARD.—"I am an Anglomaniac."—*Harper's Bazar.*

The nurse was told to give the twins a bath. Later, hearing the children laughing in bed, she said: "What are you children laughing about?"

"O, nothing," replied Edna, "only you gave Edith two baths, and haven't given me any."—*Lewiston Journal.*

Mrs. S.—"What is the name of your cat?"

Mrs. W.—"Claude."

Mrs. S.—"Why do you call it Claude?"

Mrs. W.—"Because it scratched me."—*Harper's Round Table.*

SALAD.—Take five heads of lettuce—if you can't get the heads, use the tails. Put them in water, and let them come to a boil. If they won't come, take them by the ears and lead them. For dressing, use low neck and short sleeves.—*Ben Franklin.*

GRANDPA—Don't get scared, Willie; the tiger is about to be fed; that's what makes him jump and roar so. Willie (easily)—Oh, I ain't afraid of him, grandpa. Papa's the same way when his meals ain't ready.—*Standard.*

JACK—Doctor, Laura just said that you had a beautiful mustache. Mother—Stupid child! You mustn't tell everything your sister says. Jack—But Laura promised me 20 cents if I would say it.—*Fliegende Blatter.*

A Maine editor has sent little Marion Cleveland a poodle. Most of the editors have been giving her father pointers.—*Galveston News.*

# THE DERMATOLOGIST AND THE GENERAL PRACTITIONER.*

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We have all heard much of late, true and false, complimentary and the reverse, of the expansion of the specialist in medicine, and the decadence of the general practitioner. Every now and then some part of the common of general medicine is taken up by a keen-witted business doctor, and fenced in, and it belongs thenceforth no longer to the general domain, but becomes the exclusive property of the few who claim to be specially fitted to till it. And woe betide the outsider that ventures on it: more especially if he should have that not inconsiderable share of bad luck and non-success that falls to the lot of the specialist himself just as often as it does to them.

There have come to be specialists of all the various classes of diseases, and for all the regions of the body. One set takes the eye, another the ear, a third the nerve structures, a fourth the general integument, a fifth the bones and joints, and a sixth the male genital organs. Nay, it has gone so far that we find a physician confining his attention and scientific ardor to the stomach alone, to the liver alone, to cancer and to nothing else, and even—God save the mark—to the orifices of the body solely. With the advent of the so-called "Orificial Surgeons," we seem to have almost reached the point of absurdity in specialization; and, if the tendency still prevails, we shall yet have doctors who confine themselves to the pylorus, and others who are interested only in the fimbriated extremity of the Fallopian tube.

Far be it from me, however, to descry a tendency that is universal, and therefore justified, that is inevitable and therefore not to be bemoaned. In all the arts and sciences the same process of specialization is going on. The increase in the world's population, and therefore in its workers of all kinds; the vast growth of the literature that records their labors; the increasing demands for thoroughness in what each one of us pretends to know; the heightened competition that makes pre-eminence and success in any line more and more difficult to attain; all these justify and render inevitable the subdivision of our science. And that it is by no means a new phenomena, but has occurred in other ages under similar conditions of heightened civilization and increased population, a single example will show. Of the medical profession in imperial times in Rome, Friedlander says: "The following of medicine as a trade rather than a profession led to the increase of specialists; some cut roots; others prepared salves and potions; others again applied poultices, or gave enemata, or opened blood-vessels, or applied leeches. No one, says Philostratus, a contemporary writer, can encompass the whole of medicine; this one understands injuries; that one fevers; a third one eye diseases, and a fourth, consumption. There were ear doctors and tooth doctors, rupture doctors and fistula doctors, and even doctors who treated only the diseased uvula. Martial enumerates, in the year 95 A.D., some of the celebrated specialists in Rome at that time. Carcellius draws diseased teeth; Hyginus burns away hurtful eyelashes; Fannius conquers the relaxed uvula without cutting it off; Eros removes the branded marks from the backs of slaves; and Hermes is considered the best physician for hernia. Galen mentions specialists in the operation for stone in the abdominal incision, and in the sewing together of the eyelids.

And now the question naturally arises, "Where is this process going to end?" Will it go so far that finally, in the large cities at all events, the general practitioner will give way to the specialist, each man selecting a small portion of the field and cultivating it? Such a prospect would not be an encouraging

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one, for whilst it would mean greater experience and a larger measure of technical skill, it would also imply a defective mental field of vision and a necessary lack of appreciation of the essential interaction and interdependence of the various portions of the bodily machine that does not augur well either for our science or for our patients. Compose a set of not very definite symptoms of an imaginary patient, and present them to a gynæcologist, a stomach specialist, and a neurologist; is there any reasonable doubt that we should get three different diagnoses, each locating the trouble in his favorite organ. The well-known experience of Nellie Bly a few years ago is a case in point.

But there is another possible and more desirable termination to the specialist tendency, and I think that there are signs already that show that it is under way. I believe that the present phenomenal development of specialism is a temporary and not a permanent thing; that it is a necessary incident in the progress of scientific development; that of the immense accumulation of facts and pseudo-facts there will be separated the chaff from the wheat, and only the small permanently valuable portion will be retained. Then with the store of knowledge in each department clarified and reduced to its simplest terms, with all extraneous and useless matter left out, the teaching of the special branches will be as comparatively simple a matter as that of physiology or anatomy in our schools, and its practice will be the common property of every educated physician.

Let us take an instance from the department with which I am most familiar. In the systematic text-books on Dermatology you will find a long list of diseases running up into the hundreds, and provided with formidable and confusing names. No one, unless he devotes much time and labor to the study, can hope to know them all. Nevertheless they can be reduced to a few leading classes, the diagnostic points of which are comparatively easy of recognition, and the treatment of which can be conducted along broad and well-known lines. Thus, one large class is inflammatory in nature, and we recognize that fact by the presence of the signs of general or local fever, by the febrile movement with its accompaniments on the one hand and the local inflammatory symptoms on the other. These inflammatory skin conditions, we recognize, may be superficial or deep seated, in accordance with whether the process is situated in the superficial capillary layer of the derma, or in the deeper-seated vessels. In the latter case we have, in addition to the general inflammatory signs, thickening of the skin in consequence of inflammatory exudation in its deepest layers, but no involvement of the superficial structures; in the latter we have little or no thickening, but superficial exudation from the vessels, showing itself as papules, vesicles, pustules or oozing surfaces. It is, in fact, a catarrhal process, differing in no way from a similar process in the mucosæ, and it includes the various forms of eczema, intertrigo, dermatitis, balanitis, erythema, herpes, etc.

Now, no matter what the special form may be, when the diagnosis of an acute superficial inflammation of the skin has once been made, the treatment may be conducted on similarly broad general lines. Inflammation being dependent upon an irritant, external or internal, our first aim must be to remove it. If, as is so frequently the case, it is situated in the gastro-intestinal canal, the functions of that organ must be regulated; if it is due to an external irritant, that must be prevented from further noxious action. The cause of the inflammation being thus removed or mitigated, the next step is to protect the irritated surface; and, although in certain cases certain special modes of treatment are quicker and better than others, it does not matter so very much what means we employ. Ointments and pastes, bandages and rubber tissues may be used; our main object being to keep the inflamed parts at rest and to prevent the further action of any irritants. In a large number of cases such simple means as these will suffice to give the tissues that chance for reparative action that they are always so ready to undertake if they can. We can then help nature along by the incorporation in the applications of any mild sedative or astringent remedy, zinc, ichthyol, salicylic acid, etc., in small proportion. And in the last stages of the inflammation,

when the redness is disappearing and possibly desquamation has set in, we can help matters along by the use of tar and oil of cade.

Thus in the merest outline I have indicated the broad diagnostic points and plan of treatment of a large and important class of skin diseases; and the same plan can be pursued in the other commonly-met-with classes of diseases, which do not number more than six in all. The diagnosis and treatment of dermatology can be systematized; and, so systematized, can become the common property of all educated physicians. There is no reason why the diseases of the skin cannot be placed in line with the affections of the internal organs, and be taught as they are. The main requisite at the present time is the digestion of the accumulated material, and its arrangement on the broad lines of general diagnosis and therapeusis. Then the general practitioner will no longer stand helpless, as he now too frequently does, before a case of skin disease.

Not that I believe by any means that the usefulness of the specialist will be at an end. We teach the broad principles of diseases of the lungs, let us say, in our schools, and we know their diagnosis and treatment. Yet a case of cancer of the pleura may be very obscure, and we may require the assistance of the man specially skilled in the diagnosis of affections of the chest. But the specialties are destined, in my opinion, to become a part of systematical medical education, and not merely a matter of extra voluntary clinical or special study. The doctor of the future will be taught systematic dermatology just as he is now taught the study of the general diseases.

## EIGHTEENTH CENTURY PRESCRIPTIONS.

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The following prescriptions are taken from an old book whose exact date it is impossible to state, since the cover and title page are missing. The quaint phraseology, the long "s's," and the printing at the bottom of each page of the first word of the next, assign the work to, at least, the middle of the last century. The book is in two parts; the first and shorter portion being devoted to "Receipts in Cookery, etc."; while the latter portion consists of a "Collection of Receipts in Physick and Surgery."

The author's own statement in the preface explains clearly that the work is domestic in scope, yet it must represent with some degree of accuracy, the materia medica of the times. "I make no Doubt but the Learned Gentlemen of the Faculty will be too Generous to Misconstrue this small Collection of Physical Receipts, as an Invasion of their Province or a Disrespect to their Persons. I declare myself so far from intending either of these, that, on the contrary, I esteem it a great Happiness and Blessing to be able to have a ready and constant Recourse to their Assistance. And I am proud to own that most of the following Prescriptions came from the most eminent Hands in that Profession. The rest are all Innocent and Safe." Whether the sarcasm of the last clause is accidental or intended, is an undecided question.

"A very good Snail-Water for a Consumption", is made in this manner. "Take half a Peck of Snail-Shells, wipe them, and bruise them, Shells and all in a Mortar; put to them a Gallon of new Milk; as also Balm, Mint, Carduus, unset Hyssop and Burrage, of each one Handful; Raisins of the Sun ston'd, Figs and Dates, of each a quarter of a Pound; two large Nutmegs: Slice all these, and put them to the Milk, and distil it with a quick Fire in a cold Still; this will yield near four Wine-quarts of Water very good: You must put two Ounces of White Sugar-candy

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into each Bottle, and let the Water drop on it; stir the Herbs sometimes, while it distils, and keep it cover'd on the Head with wet Cloths. Take five Spoonfuls at a time, first and last, and at four in the Afternoon."

The "Fryers Balsam" is described at length. As the ingredients are alcohol, sarsaparilla, China, Virginia snake root, guaiac, balsam of Peru, balm of Gilead, it has evident antiseptic properties. "An Oil for any Bruise or Wound" has also many antiseptic ingredients, and as the directions include boiling and straining after the addition of the oil and a second boiling immediately before it is put away "close-stopp'd for Use", it is plain that a fair degree of asepsis is also included. Bay tree, red sage, lavender, worm-wood, plaintain, rue, tormentil, scabious, comfrey, broom, rape, osmund-royal, southern wood, chamomile, charity, St. John's wort, Solomon seal, amber, rosemary, adder's spear, golden rod, herb Robert, ground pine, sanicle and bugle, turpentine, "natural balsam", oil of worms, are the active ingredients of this oil, while the excipients are olive and neat oil, in the proportion of one to three. Out of the list of herbs, a number must possess antiseptic properties and several are known to.

King's evil or scrofula receives considerable attention both in external and internal preparations. Cordials, electuaries, possett drinks, are favorite preparations, though not so appetizing as the names suggest, and there are not a few naive confessions of unpalatibility in the way of directions to take "as much as the Stomach can bear it"; "and after that drink a pint (if your Stomach will bear it) of White-wine Posset, and (if you can) drink the whole quantity at a draught", etc.

The author states in the preface that all the prescriptions are "approv'd (not from Single Instances of Success, but) from a long and repeated Experience," but he adds numerous endorsements of the virtues of individual prescriptions, in the text. Thus, of a poppy water for surfeits, to be taken "after a full or disgusting meal," he says, "'Tis not much stronger than a simple Water, but it has been the only cordial of an infirm Lady, who has used it ever since Fifteen, and she is now Ninety-seven. This of my own Knowledge." Again, after describing a mixture, this note is added: "N. B. This was the Prescription of a learned Physician; and has been long kept as a choice secret in a very charitable Family, who have made numberless Experiments of it with miraculous Success." Of two eye-salves, one to be used "if the Rheum be violent and they have Specks," the other "when the Rheum is not so violent," it is declared that they "cost a Gentleman fifteen hundred Pounds, who had them of a Jesuit, who came from Rome, to cure his Daughter's Eyes; and they have been often try'd with great success: Value these as choice Receipts." It does not seem to have occurred to the author that the large sum was a professional fee, rather than the price of a prescription.

Most of these prescriptions are wholly out of harmony with present methods, in fact the entire conception of disease is different from that now accepted, though a comparison might be made to present homœopathic practice, since the remedies are directed toward individual symptoms or groups of symptoms, rather than toward diseased processes. To cure Deafness and Noise in the Head, For Convulsion Fits, For a Pain in the Stomach, To make the Hair grow thick, To draw an Imposthume out of the Ear—are some of the headings in this collection. It is only occasionally that we recognize anything of modern repute in this collection, and the few prescriptions that would be endorsed by a physician of the present day are of the simplest character and apply, in most instances, to the external use of remedies. Here, for instance, is one that can scarcely be improved upon, provided the trouble is not too severe. "If the nail of your Toe be hard, and apt to grow round, and into the Corners of your Toe, take a Piece of broken Glass and scrape the Top very thin; do this whenever you cut your Nails, and by constant Use, it makes the Corners fly up, and grow flat."

One of the most curious articles in the entire book relates to "A Preservative against the Pestilence." Rue, sage, mint and *camphire* are among the ingredients, and the directions are to use the preparation externally, to wash the mouth with it and to snuff a little up

the nose, carrying a sponge, wet with the mixture, for frequent use when exposed to infection. Strangely enough, this formula of an age of empiricism contains drugs whose established antagonism to the development of germs should theoretically have the desired effect, yet they are utterly ineffective in practice. However, our author cites the following as proof of the value of the remedy. "From a Physician in the Duke of Berwick's Army, in the Year 1721, we were told, That four Malefactors, who used to rob the infected Houses, &c., had owned at their Execution, That they had prepared themselves from the Contagion by using this Medicine only." The writer can match this wonderful account of the warding off of contagious disease by the case of a patient who was compelled to occupy the same room with a person sick with erysipelas. The former wrapped himself with newspapers in order to keep the germs away, and really did escape the disease. Yet it would not be a safe inference to recommend newspapers as a preventive of erysipelas.

## SURGERY OF THE PANCREAS WITH REPORT OF CASE.

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Having recently operated on a case of cyst of the pancreas, realizing the comparatively few cases thus far reported, together with the fact that investigation is now being turned upon this important subject, has led me to present this paper before the Tennessee State Medical Society.

Surgery of the pancreas is yet in its infancy, and we have much still to learn. Despite all this, the many brilliant results achieved in the cases thus far treated, convince us that in a short time we will be enabled to diagnose and treat these cases with the same ease and precision as affections of kindred organs.

The slowness with which affections of the pancreas have been dealt with is, in a great measure, due to the inaccessibility of the organ and the difficulty attending a correct diagnosis.

For the literature of the pancreas and the operative procedures, the profession is greatly indebted to Dr. Senn, of Chicago, who in his recent treatise upon Tumors and Retention Cysts has pointed out many valuable suggestions.

The conditions deserving attention in a surgical way may be mentioned as those commonly found in analagous organs, as liver, etc., such as carcinoma, sarcoma, abscess, hydatids, cysts, etc. Unfortunately for us, such affections as carcinoma, sarcoma and abscess of the pancreas have only been diagnosed after death, post-mortem examinations revealing their true character. Wounds of the pancreas, partial rupture of the organ, and severe contusions have been diagnosed and successfully treated. Portions of the organ, presenting themselves in stab and gun-shot wounds, have been removed, with complete recovery. The affection however which will occupy our attention in this paper, the one with which we are best acquainted, is cyst of the pancreas.

Dr. Treves has collected twenty-four cases, sixteen of which were operated upon by incision and drainage, with one death. There is also reported six cases operated upon by complete removal of the cyst, with one recovery.

In his valuable article on cyst of the pancreas, Dr. Senn takes the position that these cysts are always the result of retention of the secretion and subsequent dilatation of the secretory duct; or in cases of laceration of its structure, there is extravasation of the secretion into the parenchyma of the gland and subsequent distention of the capsule. Thus, the pancreatic duct may be obstructed at or near its proximal end, and the entire duct and its branches become dilated similar to a varicose vein, and a large or small cyst be formed.

Some of the causes which produce cyst of the pancreas may be enumerated as follows: Obstruction of the pancreatic duct, either by calculi, or by cicatricial contraction, the product of inflammation; displacement of the organ; pressure by tumor or aneurism upon the organ or its duct, and traumatism, as will be evidenced by the case I am about to report.

The diagnosis of cyst of the pancreas is by no means an easy matter, and not a few cases are only cleared up by an exploratory incision through the abdominal walls. These cysts have been mistaken for hydatids of the liver, ovarian tumors, and in a few cases where the cysts were over an artery, for an aneurism. It is only in a few cases where the cyst has attained a large size, that a diagnosis can be assured with any certainty.

The history of the case should be carefully studied and the position of the tumor clearly outlined. The tumor is generally seen in the epigastric or left hypochondriac regions, having an elastic tense feeling, and is of rapid growth. Diarrhœa and emaciation follow, due possibly to pressure from the cyst walls, and interference with the functions of the gland. Pain is experienced in the region of the pancreas, and to this some authors add a muddy complexion of the skin. A valuable diagnostic point is brought out by the insertion of a hypodermic needle into the cyst walls, the evacuation of the fluid and the examination of the same; the fluid in the great majority of cases being of a chocolate hue. In several cases reported the tumor was of large dimensions, the cyst containing nearly two gallons of fluid.

The treatment of pancreatic cysts is divided into incision of the sac and drainage—the walls of the cyst being attached to the abdominal parietes, a drainage tube inserted, this being constantly shortened until finally removed —and the complete removal of the cyst. The objection to drainage by incision of the cyst is, in some cases, the establishment of a permanent pancreatic fistula, the escape of the fluid into the peritoneal cavity, and the re-accumulation of the cyst after evacuation.

I am impressed with the fact that the ideal operation is the complete removal of the cyst from the abdominal cavity, as it removes these objections. I realize the difficulty of this operation owing to the deep location of the organ, and from the fact that the pedicle is usually short and sometimes wanting; yet viewing the many advancements made in abdominal surgery, and the ease with which cysts of other organs are dealt with, the absolute certainty of no return has emboldened me to take this position.

On January 1st, 1896, I examined, at the Nashville City Hospital, a negro boy, aged eighteen years, for an abdominal growth. The tumor occupied the epigastric, left hypochondriac, and portions of the umbilical and left lumbar regions. Percussion dulness extended from the left nipple to two inches below the umbilicus; the tumor was tense and elastic, but no fluctuation could be discerned. In shape, it was oval, or round, smooth, and gave the patient great distress from pressure on surrounding structures. Shortly after this examination the patient vomited several times; no fremitus could be discerned, and the tumor filled snugly the portions of the abdominal cavity already described. There existed emaciation and complete loss of adipose tissue.

The following history was elicited from the patient: he was a laborer, a "roustabout" on a steamboat plying the Mississippi River. In the early part of July, 1895, while asleep in the lower bunk, he was suddenly awakened by a box weighing fifty pounds falling from the bunk above and striking him in the region of the ensiform cartilage. The pain was so intense that upon arriving at St. Louis, Mo., he was taken to the St. Louis Marine Hospital, remaining there seven days. Upon examination of the injury by the physician in charge, he was pronounced to have sustained a contusion, and was treated for this condition. For the first four days after his admission the pain was of such a severe nature that he had to be kept under the influence of morphine. After this period the pain gradually decreased and he was so much improved that he was dismissed from the hospital on the seventh day.

After his discharge he still complained of a soreness in the region of his injury,

and six weeks later noticed a protuberance in the epigastric region. He paid but little attention to this, owing to the fact that being a large eater he imagined it was due to over distention of the stomach. This swelling he noticed, however, to be gradually getting larger and larger every day.

On October 30, 1895, he came to Nashville, Tenn., to visit some relations, but said nothing to them until the latter part of November, when the tumor had attained such a size as to alarm him. By their direction, on November 30 he sought medical aid. On this date he was examined by many physicians, and as many different diagnoses made. He entered the Nashville City Hospital December 16, 1895, and as stated above was examined by me January 1, 1896.

From the history of his case, the tense elastic feeling, the loss of adipose tissue, the vomiting and diarrhœa that had attended it, although at the time I examined him he had been suffering from constipation for a short time, the pain in the epigastric region and the discomfort produced by pressure of the tumor, together with the fact that a small quantity of the fluid had been withdrawn by a hypodermic needle, presenting a light brown color, I decided I had to deal with a cyst of the pancreas, and gave it as my opinion that an operation should be performed. After consultation with several physicians, they agreeing that an operation was demanded, with the consent of the patient I operated upon him before the class on January 2, 1896, assisted by Dr. Chas. Brower, Superintendent of the Hospital and the Hospital Staff, in the presence of Drs. Warterfield, Nichol, McGannon and others.

An incision was made in the median line, extending from the ensiform cartilage a distance of four inches down to the peritoneum; all hæmorrhage being checked, the peritoneum was opened, when there presented at the external wound a round tumor covered by omentum, there being no adhesions between the peritoneum and omentum. The omentum was intimately attached to the tumor for at least three inches, and could not be separated from it. The tumor beneath the omentum presented a smooth, glistening appearance. The walls of the tumor with the adherent omentum were now seized by forceps and held stationary, the exposed portion of the tumor packed around with sterilized gauze, and a large trocar introduced into the cyst, evacuating about a gallon of light brown fluid. The cyst was now incised and explored. An attempt was made to separate the omentum from the cyst, but resulted in a complete failure, owing to the complete agglutination of the contiguous surfaces. The omentum was now cut through at the point of its attachment to the cyst, exploration made upon the exterior of the cyst and adhesions to the stomach discovered. In tracing the cyst downwards, many of these adhesions were torn loose, when finally a short pedicle was found attached to the body of the pancreas, close to the head of this organ. Fearing that these adhesions, which had already been broken up, connecting the tumor with the stomach, might give rise to serious trouble, I determined to completely remove the cyst. I was now met with firm adhesions of the transverse colon, and considerable force was required for separation, resulting in some laceration of the colon. I now encountered adhesions to the transverse meso-colon, and so firm were these, that in attempting to separate them the mesentery was torn away from the gut for an extent of eight inches. After separating the remaining adhesions from the stomach, I had only the pedicle to deal with, which was treated by a Staffordshire knot, and a portion of the pancreatic substance removed with the pedicle. There was but little or no hæmorrhage during this operation, and no other ligatures were required. The edges of the omentum, a portion of which had been removed with the cyst, were now brought together by a continuous cat-gut suture, and a portion of the omentum placed around the denuded gut, being held in position by sutures. The abdominal cavity was now carefully sponged out, and the walls approximated by silk worm-gut sutures.

My patient made an uninterrupted recovery, and was discharged as entirely well on January 26, 1896, just twenty-four days after the operation. At no time did his temperature exceed 101° and his pulse rate 110. No tympany of

any consequence developed. His bowels remained constipated for some time after the operation, not moving until the eighth day. His appetite, which was very poor before the operation, began to improve on the fourth day, and vomiting ceased on the second. Since the operation the patient has steadily improved, and has increased twenty pounds in weight. He is now in excellent health, and has had no trouble with the exception of an attack of colitis brought on by over-eating.

The interesting features of this case are:—

First. The establishment of the fact that pancreatic cysts can be produced by traumatism. The history of the patient, previous to his injury, was that of a healthy, robust boy, having at no time any conditions that would lead us to believe there was impaction in the duct, or inflammation in the surrounding structures. We are thus forced to the conclusion that in this case the commencement of the cyst is traced to the injury sustained by him.

Second. From the literature and statistics upon this subject, which I have been enabled to obtain and examine, this is the second recorded successful case treated by complete removal of the cyst, the other case being that of Dr. Bozman,* who operated, supposing he was dealing with an ovarian tumor, afterwards, however, by tracing the pedicle, discovering it was attached to the pancreas.

And finally, the absolute certainty of collateral circulation being established, when the gut (for a given portion, as in my case, eight inches) has been denuded of its mesentery, together with the additional precaution of surrounding the denuded gut with an omental graft, makes this case of exceeding interest to me.

# COMMUNICATIONS.

## TREATMENT OF STRANGULATED INGUINAL HERNIA.

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The subject of hernia is such a voluminous one that in a paper of this kind it would be impossible to do justice to more than a very small part. I have therefore chosen to limit the discussion to the treatment of strangulated inguinal hernia, because it is in the treatment of this form of hernia that the greatest advances have recently been made. Even in this branch of the subject, it will be necessary to limit the discussion to the most salient points, and I will therefore confine my remarks as closely as possible to methods of operating which I feel warranted in bringing forward as the best we can, at the present time, adopt. This will explain why I have ignored methods of treating strangulated hernia which, in a more extended article, would be deserving of complimentary mention.

A hernia becomes strangulated when its contents are sufficiently constricted at any point to impair its circulation and endanger its nutrition. The duration of time during which a bowel may remain strangulated and yet retain its vitality varies widely from three or four hours to as many days, depending mainly on the degree of constriction, and the more or less complete arrest of its vascular supply. It is a good and safe rule to follow however, to consider every case of strangulated hernia as one in which there is a total arrest of its vascular supply, and therefore one in which gangrene may take place within a few hours.

If the contents of the hernial sac consist solely of omentum, gangrene, if it takes place at all, will do so very slowly. But even in these cases the rule given

*See Senn's work on Tumors and Retention Cysts, page 687.

above should apply, for it usually happens that behind the mass of omentum there lies a portion of strangulated intestine, in which case, were we to consider only the omentum, and unduly delay relieving the constriction, the result would be disastrous. A patient with a strangulated intestine, unless relieved by nature or by art, is doomed to a sure and speedy death; and if the operation is delayed until gangrene of the bowel has taken place, his chances for recovery are exceedingly small.

There is a striking uniformity among surgeons in advocating immediate relief by operation, of a strangulated hernia which cannot be reduced by taxis. The physician is more prone to delay in this matter. This may be attributed to a natural repugnance to the use of operative methods of treatment, or to a belief in the ultimate efficacy of taxis, or in the use of such palliative treatment as cold, elevation of the buttocks, and morphine. He sees less often than the surgeon the disastrous results of delay, and is therefore less impressed with its evils. I feel, however, that I am keeping strictly within the limits of truth and justice when I assert that the physician or surgeon, who, in a case of strangulated hernia fails to employ operative methods for its relief, immediately after the nature of the hernia has been determined and taxis has been applied judiciously and to a moderate extent, is directly responsible for the ill results that may accrue from such delay, and should be so held by the patient's friends and by the profession. Of course there may be unavoidable delays for which the physician should in no wise be held responsible. The objection to an operation may, and frequently does, come from the patient, in which case the physician should distinctly and forcibly present the evils of delay, and thus clear himself of the responsibility therefor. That he may be distant from professional aid and is himself not a surgeon, are scarcely sufficient excuses for unduly delaying the operation; for, of the two evils, delay and an inexperienced operator, the former is decidedly the worst. Every physician should be at least able to operate, in an emergency, on a strangulated hernia, and no more instruments are absolutely necessary than he carries in his pocket case.

In case of unavoidable delay an ice bag or cloths wrung out of cold water may be applied on the hernial tumor. This, together with elevation of the buttocks and flexure of the thighs, will, in exceptional cases, affect the return of the hernia, and, in the absence of more radical treatment, should be resorted to.

It is customary to apply taxis immediately on seeing a hernia. This is often successful but should not be prolonged, nor roughly applied, as it may injure an already damaged gut. In one case where I applied taxis without being, as I thought, rough in my manipulations, I found, on doing a herniotomy, that I had produced an extensive hæmorrhage between the serous and muscular coats of the bowel.

When taxis fails, the patient should be anæsthetized, preparation being made in the meantime for an operation. It is the custom to repeat the taxis under anæsthesia, and this custom has received the sanction of the profession, but I firmly believe, and here assert, that it is a pernicious custom and should not be recommended for the following reasons: It is seldom successful, and when it fails it necessarily prolongs the time during which the patient is under the anæsthetic; besides, it injures the strangulated bowel to a greater or less extent. If successful, it deprives the patient of the benefits of an operation which aims, secondarily, at the radical cure of his hernia, and leaves him subject to a renewal of the strangulation. It may be advanced in favor of taxis that the patient may be so weakened as to be unable to withstand a herniotomy, therefore taxis, if successful, would be perferable; but this may be met with the statement that in cases where the patient is so weakened by the strangulation it would, in all probability, be unwise to return the gut without first inspecting it, and determining if it has retained its vitality.

The operation undertaken for the relief of strangulated hernia has for its object, first, to free the strangulated part of its constriction, and second, to prevent a return of the hernia by closing the hernial opening. This has been accomplished in a variety of ways, many of which

have been rendered obsolete by newer and better methods of operating.

The older operators were content to relieve the constriction, return the hernial contents, and close the wound, without any attempt at a radical cure of the hernia. At the present time, however, such an operation would be incomplete, and could only be justified by an extremely weakened condition of the patient, whose life would be seriously endangered by prolonging the operation, in the attempt to effect a radical cure.

The operation of herniotomy has been divided for convenience into four steps, as follows:

1. The external incision, the opening of the sac, and liberation of the constriction.
2. The treatment of the hernial contents.
3. The treatment of the sac.
4. The closure of the hernial canal.

In the description of the operation I will, for the sake of brevity, omit any mention of antiseptic details, and for the same reason will only describe the operative procedures which I think will yield the best results.

The skin incision should be made parallel to the inguinal canal and directly over its external opening. This incision gives the freest access to the constricted point and is decidedly better than the old incision over the prominent part of the tumor, which necessitated the cutting of the constriction at a point out of sight and often difficult to reach.

The tissues should be divided without respect to their anatomical arrangement until the sac is exposed. At this point there is sometimes confusion, as the coverings of the sac are often mistaken for the sac itself. The sac may be identified by its bluish color and by the fact that if pinched between the finger and thumb its two surfaces may be felt to glide over each other, and in herniæ of recent formation the contents are often visible through the sac.

Before the reign of antisepsis, it was a much mooted point whether the sac should be opened or not, but now there is no division on the subject, for the following reasons: There is no longer a dread of opening the peritoneal cavity; the constriction may be in the sac itself, consequently the return of the gut enclosed in its sac would not in these cases relieve the strangulation; the gut might be hopelessly damaged and the condition unrecognized; and lastly, when the strangulation has continued a considerable time there is an exudation of fluid, which, as will be shown later, may, if permitted to enter the peritoneal cavity, set up a virulent peritonitis. The sac should, therefore, be freely opened and its contents exposed.

If the constriction is very tight, the hernial sac will be distended with fluid, which is, at first, serous in character, later becomes darker from the exudation of blood corpuscles from the wall of the intestine, and, in extreme cases, where the gut has become gangrenous, becomes purulent and has a distinctly fæcal odor, due to the fact that the damaged bowel offers but feeble resistance to the passage through its wall of the bacillus coli communis and other micro-organisms which will be found in the surrounding exudate. It follows, therefore, if we desire to keep the peritoneal cavity intact, that the fluid formed within the sac should be carefully washed away with warm distilled water before the constriction is removed.

If the incision in the overlaying tissues is made as directed, over the external opening of the canal, the division of the constriction is a very simple matter. It is usually exposed to view, and may be divided on a grooved director with a knife or a pair of scissors as we see fit. The constricting tissues should be divided directly upward, and only sufficiently free to permit a return of the intestine. It is better, however, to make the incision freer than is necessary rather than to err on the other side and have a difficulty in returning the gut. Should any vessel be cut, it is exposed to view and easily secured.

The condition of the bowel next requires attention. It may be in any stage, depending on the tightness and duration of the constriction, from simple congestion to gangrene. A gangrene bowel has a dirty grayish or slaty color. It feels more like leather than intestine, and does not change in color on liberation of the constriction. It is not always easy to determine the viability of the bowel; but if there is a doubt about it, it may be settled by irrigating the bowel with warm distilled water, and a little time

given for the re-establishment of the circulation, or it may at once be decided by making a small incison through the serous and muscular coats of the bowel; if the incision bleeds, the bowel lives; otherwise it is dead.

Sometimes only a very small patch of the bowel is gangrenous. These localized spots of gangrene will usually be found at or near the point of constriction, where pressure effect is added to that of strangulation. It is important, therefore, in every case, to draw the loop of intestine downward, and carefully inspect the points of constriction before replacing the bowel.

If the viability of the bowel is assured it should at once be returned to the abdominal cavity, and the hernial opening temporarily plugged with a gauze pad to which a pair of hæmostatic forceps has been secured to prevent the pad from slipping into the abdominal cavity.

If the gut is dead, there are two methods of treatment which we may adopt. The first and simplest is to fasten the bowel *in situ* and freely incise it to the full extent of its gangrenous portion. This, of course, permits the escape of the intestinal contents, and relieves the obstruction; but it has such serious objections that it should only be resorted to when the patient is in such a weakened condition that further operative interference would be almost certainly fatal.

Aside from the extremely disgusting condition that a patient with an artificial anus must submit to, if he recovers from the immediate effects of the operation, death will probably ensue in a few days from inanition as a result of the escape of the intestinal contents through the wound, unless the incision in the bowel happens to be in the lower part of the ileum, when a fatal termination may be delayed. At any rate, the probabilities are that the patient's condition will be no more favorable for a secondary operation of excision of the intestine than it would be for excision at the primary operation, and the difficulty in maintaining asepsis would be infinitely greater. The indications for delaying excision of a gangrenous gut should be very clear before we should resort to it.

The second method of treating a gangrenous gut, namely, excision of the gangrenous portion is the one we should adopt, except in cases where death is imminent and further operative procedures inadvisable. It is all important in this operation that it be rapidly accomplished, and for this purpose several excellent mechanical contrivances have been devised, notably Senn's decalcified bone plates and Abbe's catgut rings for lateral anastomosis, and the Murphy button for either lateral or end to end anastomosis. The latter device is at the present time very generally used and has given excellent results, but there is a growing tendency among surgeons to discard mechanical aids, and to rely wholly on the suture.

The method of lateral anastomosis as described by Abbe has much to recommend it, as it gives ample communication between the anastomosing bowels. I think, however, that where a portion of the bowel is resected, an end to end anastomosis is preferable, as it may be more quickly accomplished, and this is a vital point in the operation. The method of performing end to end anastomosis is as follows: The fold of bowel to be resected is drawn out of the wound so as to be easily accessible, a strip of iodoform gauze is then passed through a narrow slit in the omentum on either side of the gangrenous portion, about two inches external to the point where we desire to divide the bowel. These strips are tied sufficiently to prevent extravasation of the intestinal contents. The bowel is now divided well in the healthy tissue at right angles to its axis.

A "V" shaped portion of the omentum, with its base towards the bowel is also excised, care being taken that its base is less by half an inch than the the length of the excised gut; otherwise gangrene of the extremity of the bowel may supervene. The open ends of the bowel should now be thoroughly cleansed by irrigating the parts with distilled water or a boric acid solution, and fresh warm towels laid around the site of the operation.

When the bowel is divided, the muscular layer contracts, carrying with it the serous covering and causing the mucosa, and the submucosa, to project. This facilitates the passage of the first row of sutures, which are inserted in the following manner: The extremities of the bowel are held by an assistant so that

they lie parallel to each other with their mesenteric borders in apposition; with a cambric needle and fine silk a suture is inserted at the mesenteric attachment, passing first through the mucosa and submucosa, avoiding the muscular and peritoneal covering; then it is passed in the inverse order, that is, through the submucosa and the mucosa of the other extremity of the bowel, and tied. This brings the knot within the bowel. A similar suture is then applied about half an inch to the side of this one and so on until the bowel is encircled, requiring in all about five or six sutures. When the last suture is tied it will be found that it will lie external to the submucosa and should be tucked into the bowels with a needle. This row of sutures has for its object the apposition of the extremity of the bowel so that the mucosa is apposed. It is not expected that it will prevent extravasation, but rather serve the purpose of fixation of the ends of the bowel in order that the suture that follows and seals the bowels may be properly applied. This suture is called the Lembert suture, and may be applied either as an interrupted, or as a continuous suture. The latter is preferable, as it may be applied much quicker. This suture brings the serous surfaces in apposition and should be inserted about 5 mm. from the edge of the bowel, passing through the serous and muscular coats, then out through the serous coats quite close to the margin of the bowel. It is then re-entered on the opposite side in the inverse order, through the peritoneum close to the margin of the bowel, through the muscular layer, and out of the peritoneum about 5 mm. from the edge of the bowel. This completes the suture, which should be tied if an interrupted, or tightened if a continuous suture. It is advisable to begin at the mesenteric attachment of the bowel and completely encircle it with sutures inserted about an eighth of an inch apart. Particular care must be taken that the peritoneal investment at the mesenteric borders is thoroughly apposed, as this is a point where the peritoneal covering of the intestine is deficient. The cut edges of the "V" shaped section of omentum should be apposed by a row of continuous sutures beginning at the apex and ending at the bowel. The bowel should be irrigated again and returned to the abdominal cavity, provided that we are satisfied that accurate apposition has been obtained. If there is a doubt on this point a second row of Lembert sutures may be inserted; but this has the objection, aside from the waste of time, that it may invert too much of the bowel and possibly lead to stricture.

In some cases where the gangrene is limited to a very small area of the intestine, it is advisable to infold the gangrenous part by a row of Lembert sutures inserted in the healthy margin, thus sealing off the general peritoneal cavity, and permitting the gangrenous part to slough into the bowel. I have seen my colleague, Dr. J. J. Buchanan, successfully employ this method. It is only applicable, however, in those cases where the gangrenous patch is so limited that its infolding does not unduly constrict the bowel.

Many herniæ contain omentum as well as bowel, and not infrequently the contents are wholly omentum. If the omentum is inconsiderable in amount, and not adherent to the sac, it should be returned to the abdominal cavity. In other cases, the omentum may have such firm adhesions to the sac, that its detachment would give rise to a troublesome hæmorrhage; and in large, irreducible herniæ the amount of omentum may be so great that we would hesitate to return it to the abdominal cavity, which had become accustomed to its absence. In these cases, the omentum should be amputated close to the neck of the sac, and the pedicle fixed, if thought advisable, to the inner side of the canal. The whole omentum has, under these circumstances, been amputated with satisfactory results. In one case of enormous omental hernia I amputated almost the entire omentum, which was loaded with fat and weighed 27½ ounces.

Having disposed of the contents of the sac, the sac itself should be attended to. We may either remove it, *in toto*, or simply excise its neck, leaving the body of it untouched; there is no fixed rule on this point. We may simply say that if the sac can be easily enucleated from its bed it should be removed, otherwise we should content ourselves with isolating its neck and dividing it

between two ligatures, the upper ligature being placed as close to the peritoneal cavity as possible; the abdominal end of the stump should be pushed well upwards, and out of the way of the subsequent sutures. When the body of the sac is left behind, it undergoes atrophy or forms adhesions that obliterate its peritoneal investment. When the sac is removed, it is important to control all bleeding, as even the smallest vessel may give rise to an alarming hæmorrhage, if permitted to bleed into the loose scrotal tissues.

In infantile herniæ the sac is so intimately adherent to the tissues of the cord that it is difficult or impossible to isolate them. It is advisable, in these cases, to leave intact the portion of the sac that is adherent to the cord, and proceed with the remainder in the ordinary manner.

Having disposed of the sac, the last, but not the least, important step of the operation is begun, namely, the closure of the inguinal canal.

No operative procedure in surgery has been the subject of so much experimentation as the operation for the closure of the inguinal canal, and few have undergone such radical changes. The operation of yesterday is discarded to-day, and the operation of to-day may be superseded by a better to-morrow. I will, therefore, only take up your time by describing the method which is now in vogue, and which has given better results than its predecessors. It is called the Bassini operation, after the Italian physician who devised it.

It consists in forming a new canal for the spermatic cord, separating it from its bed, and isolating it in such a manner that the conjoined tendon of the transversalis and external oblique can be sutured to the shelving edge of Poupart's ligament, a row of interrupted sutures being used for this purpose. The lower suture should include the edge of the rectus muscle as it is all important that the canal be completely closed at its lower angle. The spermatic cord is now dropped and permitted to lie on top of the sutures. A second row of interrupted sutures is used to unite the aponeurosis of the external oblique to Poupart's ligament, over the spermatic cord. The suture of the skin completes the operation.

This operation has undergone various but unimportant modifications. In a number of cases I have used only one row of buried sutures, which included the aponeurosis of the external oblique and the conjoined tendon on one side and Poupart's ligament on the other, the spermatic cord therefore lying on the external oblique and directly underneath the skin. This method has given good results and, of course, can be more quickly accomplished than by the double row of buried sutures, besides it diminishes, by reducing the number of buried sutures, the risk of infection from this source.

As this paper deals solely with the mechanical and technical problems presented in strangulated hernia, I will not enter into the after-treatment, and might here draw it to a close, with the explanation that I have selected, for the purpose of illustration, the typical case with which we usually meet. It should not be forgotten, however, we may meet in any hernia, anomalies that may perplex the operator. To illustrate what I refer to, I append the history of some cases that have occurred in my own practice.

Case 1. J. M. æt 35, was admitted to Mercy Hospital suffering from a large scrotal hernia, which had been strangulated for three days. The patient gave a history of having been ruptured five years before and was wearing a truss since that time, until the present hernia decended into the scrotum and became strangulated.

As soon as the constriction was relieved and the strangulated gut restored to the abdominal cavity it was noticed that there was a peculiar bulging forward of the posterior wall of the sac, caused by a mass, the nature of which it was difficult to determine. In order to perform the radical operation for hernia the sac was dissected up to the internal ring, exposing at the bottom of the wound the mass already referred to. The weight of evidence was in favor of this mass being an old irreducible hernia, and a point was selected where, if it was a hernia, it was thought the sac would not be adherent to its contents. This was carefully incised, exposing within a coil of intestine, the walls of which were so thickened and its surface so altered by firm adhesions

to the sac as to be almost unrecognizable. With considerable difficulty the adhesions were broken down. The finger could then be passed with facility between the gut and its sac, and the continuity of the latter with the parietal peritoneum demonstrated. When the gut was liberated from the adhesion to its sac it became distended with gas. It was then replaced within the abdominal cavity. The sacs of both herniæ were tied as high up as possible and cut off, and the common pedicle of both sacs was sutured to the pillars of the ring and the operation completed in the ordinary manner. The subsequent course of the case was marked only by the development of an orchitis and sloughing of some of the connective tissue bands that were torn in dissecting up the two hernial sacs.

The chief point of interest in this case is the presence on the same side of two inguinal herniæ, one of which was strangulated and the other not. The explanation given by Dr. Buchanan at the time of the operation seems the most rational one. He thought that the hernia that had been formed five years ago was the direct inguinal one, that had never been reduced, though during this period the patient had constantly worn a truss. The gut in the meantime had, however, become firmly adherent to the sac. The strangulated hernia was probably of recent origin, and had descended obliquely through the inguinal canal.

Case 2. R. McC. was referred to me on August 16th by Dr. W. D. Kearns. This patient gave the following history: On August 12th, while lifting, she felt something give way in the left groin, and on examination discovered a tumor about the size of a hen's egg in that situation. From this time she suffered from nausea and was much distressed by the pain of the tumor, although she was able to come to my office on the fourth day. On examining the tumor I found it to occupy the region of a femoral hernia. It had a doughy feeling as if it might contain omentum, there was no impulse on coughing, and there had been no constipation. I had her at once removed to the Mercy Hospital where I operated on her, and found that the tumor consisted of the left ovary and Fallopian tube which had slipped through the femoral opening and lay enclosed in a peritoneal sac, over the femoral opening. The ovary and tube were much swollen and congested. I enlarged the femoral opening and, after being assured that the circulation in the tumor was intact, returned the ovary and tube within the abdomen. There had been no protrusion of either intestine or omentum, and the patient had never at any previous time suffered from a hernia. Her recovery was uninterrupted and she left the hospital on September 13th.

Case 3. This is a case of Littre's hernia which was sent to me by Dr. J. H. O'Brien, with the history of having suffered for two weeks from intense abdominal pain, together with persistent vomiting and constipation. At the end of two weeks the vomiting ceased, the bowels moved, and a diarrhœa set in. About this time a tumor formed over the femoral region, which became inflamed, and fluctuated. The doctor opened this tumor, which contained pus, the escape of which was followed by an escape of the contents of the bowel. At this time I saw her in the Mercy Hospital where he had sent her under my care. I found an angry looking inflammation over the groin, in the centre of which an opening existed through which the bowel contents were leaking. I enlarged the opening freely and found that I could pass my finger into an opening in the bowel which communicated externally. The opening in the bowel rapidly closed, and in about two weeks the contents of the bowel ceased to pass through this channel.

In this case what had taken place was a partial strangulation of the small intestine, or else the inclusion in the femoral canal of an intestinal diverticulum, such as Meckel's, which became strangulated. The strangulated portion of the bowel sloughed, the contents of the bowel escaped and set up an acute suppurative inflammation in the subcutaneous tissue, which was opened, or, in time, would have opened itself, and thus nature effected her own relief. This form of hernia is not uncommon, and as it does not, on account of only a part of the bowel being occluded, form a tumor, it may readily be overlooked; or if looked for,

may not be detected. The unusual part of the case is the fact that the patient was able to live until the destructive process which gave relief was affected, and also, that without any further operative proceeding than opening the abscess, the case went on to a cure. By that is meant that the sinus closed up, and the contents of the bowel resumed their natural course. I have personal knowledge of another such case which occurred about eight years ago in the practice of the late Dr. John Dickson, and which followed the identical course pursued in this case. I have also seen other cases where only a part of the bowel was occluded, but these cases either resulted fatally, or were relieved by herniotomy.

## CURRENT LITERATURE CONDENSED.

### Ichthyol in the Treatment of Diseases of the Uterine Annexa.[1]

Previous to four years ago it was my almost uniform advice to remove the tubes and ovaries when diseased. This was due to my impression that nothing short of operation would remove the condition. No fear of the result of operation has influenced me to discard it, as it has been my good fortune never to have had a fatal result after oöphorectomy.

To me the effects of ichthyol in the treatment of these at one time intractable diseases are perfectly marvelous. Were I to give instances of a very small percentage of cases which I have seen beneficially affected and cured by the simple method of applying ichthyol tampons, I feel assured that operations of the serious nature necessary for the removal of diseased appendages would rapidly decrease to a considerable extent. Careful observation has led me to the conclusion that rarely, if ever, the tubes or ovaries become diseased independently of preexistent disease or lesion in the uterus or cervix. I make the reservation that cystic, malignant, fibroid and tuberculous affections may be excluded from this category and are certainly beyond the range of ichthyol as a therapeutic agent. We rarely find salpingitis and its sequelæ without a preexisting endometritis; also, when there is a laceration of the cervix and a diseased ovary be found, it will be invariably found on the side of the laceration. So far as my experience teaches me, it is not necessary to repair the cervix to ensure recovery of the endometrium; but the chances are that the recovery will not be permanent if the lesion is permitted to continue, and certainly the ovary will not have nearly such a good chance if trachelorrhaphy is not resorted to.

In treating inflammatory conditions of the ovaries and tubes, it is absolutely necessary to remove the primary morbid conditions which have given rise to the secondary affections. Two marked cases will suffice to indicate the line of treatment which I have found most beneficial, as both of these ladies came to me from England for treatment, and in both instances removal of the ovaries had been recommended by men whose reputations are of the highest order. Both patients were married and had borne children; the one had been an invalid for eight years and the other for six, and during these periods both had been sterile. One ovary in each case was enlarged and exceedingly tender, while the other was diseased to a less marked degree. In both instances endometritis with considerable hyperplasia existed and the general health was very much reduced, and great pain on locomotion was experienced by both. I commenced the treatment by curetting, employing my dredge curette, and afterwards applied iodized phenol once a week to the whole of the endometrium, while a tampon saturated with ichthyol was introduced bi-weekly. This treatment was kept up for about three months in each case, a gradual improvement in health and relief of the local symptoms being the result. One of these patients (the younger of the two) be-

[1] Robert Bell, M.D., F.F.P. and S.G., *Edinburgh Medical Journal*, April, 1896.

came pregnant within a year afterwards and was delivered of a healthy child at the full term. Both are at present in good health. In these two instances there was no cervical lesion, but a history of subinvolution. In another case, with gonorrhœa shortly after marriage, sterility existed for twelve years, and both tubes were diseased. Curetting and the bi-weekly application of iodized phenol, followed each time by the introduction of a glycerin and alum tampon, was sufficient to restore the integrity of the uterus and tubes after a prolonged course of treatment, but I am convinced had the effects of ichthyol been known, cure would have been more rapid. As it was, however, when the morbid condition disappeared, a child-bearing epoch was established and continued for some years.

To my mind, therefore, if we make it our primary object to treat those affections of the uterus which are within reach and succeed in restoring the organ to a healthy condition, we have a most reliable and almost uniformly potent agent in ichthyol where inflammatory conditions of the uterine appendages coexist.

---

**Fracture of the Third Cervical Vertebra—Recovery.**[2]

The patient, a strong, healthy boy, fourteen years of age, was run over by a heavy wagon. He sustained a comminuted fracture at the junction of lower and middle third of the femur, a fracture of the inner condyle of the humerus, a fracture of the styloid process of the left ulna, a fracture of the left clavicle close to the articulation of the shoulder joint, a fracture of the lower maxilla, a fracture in the left temporal region of the skull running into the petrous portion, and a fracture of the third cervical vertebra, involving also the fourth and fifth. With all this, I present him to-night with only the following defects: Partial paralysis of the muscles of the neck, shoulder, thorax, and forearm on the left side; anæsthesia of the integument of the right side up to the median line of the scalp and neck, and a point of anæsthesia on the dorsal surface of the right forearm at about the point where the musculo-spiral nerve becomes superficial.

Immediately after his injury I was asked to see the boy, and found him sitting, supported by some one, in a chair in a back room of a drug store. He was cyanotic, his head having fallen on one side and respiration ceased. I grasped his head and put it on the stretch and instantly respiration began. I could also feel a sensation as of crushed bone in the left temporal region, and a frightful hemorrhage was continuous from the left ear. The immediate symptoms were, complete paralysis of both arms and forearms, paralysis of the muscles of the left side of the face, and hypersensitiveness to touch; the left pupil was dilated and there was no reaction to light; the left side of the neck was hyperesthetic, while on the right side of the face and neck motion was normal, but anesthesia complete; respiration was thoracic; chest motion was very shallow, but it gradually improved; slight hemorrhage from the ear persisted for five days. The various fractures had suitable dressings applied and the boy was put to bed with the neck extended. About the tenth week the callus in the neck forced the head to the right and overstretched the sterno-cleido-mastoid and other muscles, and prevented them from counteracting the companion muscles on the other side. The patient was able to walk around unsupported, and even to bring the head into proper position for one-half minute or a minute, but a plaster cast and bandages like Sayre's were applied to correct the deformity.

A recent examination of the boy shows some atrophy of the pectoral muscles, the serratus magnus, deltoid, biceps, rhomboid and scapular muscles; sensation remains as stated above. The boy is able to carry his head in an almost correct position early in the day, but becomes exhausted later. This change in the position of the head occurred quite suddenly; one day, he says, something snapped in the muscular portion of the unaffected side of the neck. He has worn no support of any kind for three weeks and an improvement is noticeable in the power and size of the muscles.

[2] S. E. Kæstlen, M.D., *Cleveland Journal of Medicine*, April, 1896.

### The Extraordinary Effect of Cold in a Case of Sclerosis.[3]

The patient is a man thirty-six years old, thirteen years a teacher, eleven years a professor of astronomy, accustomed to night work in an observatory until two A.M., at all seasons, The family history is negative except that his mother has been a victim of nervous dyspepsia and nervous prostration for the last thirteen years.

The patient had suffered from insomnia and severe headache for a number of years, but these passed off before the present trouble began. The general health has been so good that he has five times satisfactorily passed examinations for life insurance, the last time being in 1893. In 1889 at the close of the summer term he had nervous prostration resulting in inability to walk more than a mile without extreme fatigue in the legs. In a month he was again feeling well. In the spring of 1890 the left arm, became numb and practically useless, and after being unable to work for six months a small neuroma was removed from the site of an old injury in the left index finger and perfect use of the arm resulted. In 1891 fatigue in the legs was noticed and a tendency to stumble after walking a few miles; then disinclination to walk over half a mile. The following summer he strained his back and was unable, for a month, to walk more than a quarter of a mile. Both legs became numb and the left one dragged in walking This disappeared and his general health increased under electricity, general massage, etc. In February 1894, after sleeping in a cold room and becoming thoroughly chilled his loss of ability to walk progressed and he began to use crutches. The sacral region is the only part apparently affected excepting that lately there has been a feeling of irritation in the anterior part of the coccyx. Loss of force in micturition and difficulty in retaining urine had been noticed, but improved under treatment. The urine is normal. Exaggerated reflexes were noticed in 1890 and have gradually become more exaggerated, especially when the patient is tired.

The pain is a sensation as though the legs were wound with cords until the circulation became impeded and, in addition, were seized by intense cramps. The first period of pain lasted four or five weeks, then was mitigated for a year, and then returned, gradually extending from a band, two inches in width, just above the knee until it reached the lumbo-sacral region. It is somewhat relieved by flexing the knees, is more intense when the feet are swollen; and is worse in the morning than at night. It is slightly lessened by acetanilide; not at all by thermo cautery—cold baths, or cannabis indica. Warm baths and counterirritants make the pain unbearable. The mental power and power in the arms is good. Appetite is good. Massage seems to relieve the spastic condition of the muscles and improve tone, but all treatment seems useless.

In the winter of 1893 the patient noticed that after remaining in a temperature of 10° F. or lower for about an hour, he could walk comparatively well, and with much less pain. Many times the present winter after riding without overcoat or heavy laprobe at a temperature of zero for three-quarters of an hour he could repeatedly walk across a room twenty feet wide, taking steps about twenty inches long, and without the aid of crutches; at this time also there was no spasm or severe pain. This ability disappeared in about fifteen minutes after coming into a warm room.

[3] C. M. Hollister, M. D., *University Medical Magazine*, April, 1896.

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### It Was Hard Work Too.

"Are they perennial bloomers?" he asked of the pretty florist, as he selected some flowering plants.

"Sir!" she said indignantly; "this is no bicycle shop!"

And it took him some time to explain matters.

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"We don't print any such stuff as that," said the editor, loftily, as he handed back the manuscript. "Well, you needn't be so haughty about it," retorted their regular contributor; you're not the only one who won't print it."—*Pearson's Weekly.*

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A man is what he eats.

1853–1896

# THE MEDICAL AND SURGICAL REPORTER

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PHILADELPHIA, SATURDAY, MAY 9, 1896.

## EDITORIAL.

### THE PHYSICIAN'S RIGHT TO PROTECT HIS FAMILY.

Our attention is called to this subject by much recent comment on the case of a celebrated English practitioner who has been fined for violating professional secrecy in informing his wife of the moral status of one of his patients who was also an acquaintance of his family. We grant that in this particular instance the spirit of professional confidence was violated and that the physician, through his wife, became the source of considerable ill-natured gossip for which damages might rightly be collected.

We do not, however, agree with some of the generalizations to which editorial comment has led. We believe that not only does charity begin at home, but that the duty of an individual to himself and his family takes precedence of any duty that may devolve upon him in his relations to the world at large—excepting of course, risks which lie directly in the line of one's work. Let us suppose, that through his attendance on a patient, with whom a physician also has business dealings, the latter learns that the former is dishonest or insolvent. Shall he argue that he has no right, as an individual, to make use of information obtained as a physician and proceed with negotiations which must inevitably result in financial loss? Such a course of action, however honorable in theory, would be universally condemned as

Quixotic. Let us go a step farther. Suppose that the investment were not of the physician's own money but of that held in trust for his wife, or child, or friend. Should he proceed blindly to involve a trust-fund in ruin? We do not mean to imply that he would be justified in an explicit statement of his reasons for withdrawing from a proposed investment, but we are ready to defend the right of one so situated to act in accordance with the dictates of business wisdom and business honesty, though the natural inference from his action would be detrimental to the reputation of his patient.

Popular sentiment has outgrown the period of development when unmixed admiration was bestowed on the boy who stood on the burning deck and on the light brigade. Unreasoning, bull-headed devotion to duty without regard to future duties, is no longer an ethical ideal.

Suppose, as in the case which has given rise to the discussion of the claim of professional secrecy, the matter involved was not pecuniary, but was one touching the honor of a wife or daughter. For one reason or another, considerably more than half the physicians of the country have their offices in their residences, and it is inevitable that domestic and professional life shall mingle to some degree. It is usually considered expedient and, from the standpoint of the average patient, desirable that some social acquaintance shall exist between members of the doctor's clientele and of his family. We purpose, at some time, to call attention to objections to this custom. At present, we allude to it, merely as an existing fact. This being the case, we hold that it is the moral right—yes, the duty—of every physician to protect his household, by suitable warning, against any patient who is not a desirable and fit companion. We have already expressed the conviction that it would be his duty to use information, however acquired, to protect the financial interests of those depending on him. We believe no one would question the propriety of a warning against the contagion of disease. It is a strange code of ethics that would deprive him of the right to ward off from those who look to him for protection, a possible loss of character or the contagion of immorality.

Some object that the oath of secrecy should be paramount. To such we answer that we uphold nothing partaking of the nature of gossip about patients; we simply claim the right to warn, without entering into details, against evil communications. Law and, we believe, justice, except a promise of any kind from applications which are unreasonable and retro-active. It is good morals as well as sound policy that a man may protect himself against accidental risks occurring in his business or professional relations. Is it reasonable to question the extension of the same principle to his wife and family? What does the law establish in regard to the marriage relation in other matters? Especially severe punishment is provided for those who commit a crime after joint deliberation. Yet the most diabolical plot hatched by husband and wife cannot be punished as conspiracy, since "husband and wife are one". This unity is considered so absolute that a man, when he marries, sacrifices his right to individual ownership of real property and the law of *meum et tuum* is set aside in favor of a married man. With such precedents is it just to hold that a physician cannot consider his own and his wife's interests identical to the extent of protecting her from derogatory acquaintances?

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The seat of courage is the stomach.

# CORRESPONDENCE.

## FRACTURE SINE SHORTENING.

MR. EDITOR:—

In your issue of April eleventh on page 457 I notice a report of two cases of treatment of fractured femur *sine* shortning of the limb. This report is made by A. R. Small, M.D., of Chicago, Ill. I am interested in this article from the fact that I have been so fortunate as to have treated four cases of fracture of lower limbs within three years, and all with scarcely any appreciable shortening. All of my cases were treated with plaster-of-Paris dressings and simple pasteboard splints. The last case that I treated was that of a school-girl who had her femur fractured at the upper third about four inches below the hip joint. The fracture was caused by direct violence. She was thrown backwards out of a wagon, and her foot and leg were twisted around in the wheel. There was quite extensive bruising of the soft parts. Four hours after the accident I reduced the fracture under chloroform narcosis, and applied pasteboard splints and plaster-of-Paris bandages. In using pasteboard splints my plan is to select the heaviest pasteboard I can get. Then, with a straight edge and a sharp knife, make a number of incisions lengthwise of the splint, being careful not to cut more than half way through the pasteboard. Then I bend the splint longitudinally around the limb after surrounding the fractured limb with one layer of cotton wadding. Then place the splint on the reverse side of the incisions, and wind the muslin bandage moderately firm over the splint. After bandaging the limb with a few turns of a muslin roller bandage I then wind over that my plaster-of-Paris bandage, wet, and to make it still more firm I make a thin paste of plaster-of-Paris and water and smear the whole limb with my hands with this mortar.

I have always had the very best success with plaster-of-Paris bandages, and in using it I never forget to put about a teaspoonful of salt in the water that I mix my plaster with.

A. O. STIMPSON, M.D.

Thompson, Pa.

## ICE IN PNEUMONIA.

TO THE MEMBERS OF THE MEDICAL PROFESSION:—

My two collective reports already published on Ice-Cold Applications in Acute Pneumonia give a record of one hundred and ninety-five cases so treated with seven deaths, or a mortality rate of 3.58 per cent.

Being desirous of making as full a report as possible on this subject, I take the liberty of asking those who have tested this measure to kindly give me the result of their experience. Full credit will be given to each correspondent in the report which I hope to publish. Blanks for the report of cases will be furnished by me on application.

THOMAS J. MAYS, M.D.,
No. 1829 Spruce Street,
May 1, 1896. Philadelphia.

Little Mamie read on her Sunday-school card: "God makes, preserves and keeps us." Looking up suddenly, she said: "Mamma, what do you s'pos He does with 'em all?" "With what, my dear?" "Why all those preserves?"—*American Grocer.*

When a man asks you for a candid opinion of his novel, or his picture, or his new baby, he generally means a sugar-candied opinion; and if you want to be popular, it won't be wise to forget this little fact.—*New York Observer.*

Blood stains, which are so often with difficulty removed from the hands of surgeons, especially around the finger-nails, may be made to disappear readily by the use of tartaric acid.

# ABSTRACTS.

## THE PUNISHMENT OF A CRAZE.

It is rather surprising that the small-pox epidemic in Gloucester, England, has not been attracting more attention in this country. In the present generation, serious epidemics of small-pox have been so rare that the world has almost forgotten that this disease was, before Jenner's great discovery, one of the most universal scourges of mankind. Since the general introduction of compulsory vaccination, it has ceased to be looked upon as one of the gravest items in the list of the natural ills that flesh is heir to, but has come to be thought of as one of those rare afflictions which no person need expect to have to undergo. This change has been so extraordinary, and has been so distinctly connected with the use of vaccination by the comparison of specific experiences which differed only in the presence or absence of that preventive, that the world might well have been convinced—as it has been—even without the assurance of professional authority, that vaccination is an indispensable as well as an efficient safeguard against what without it would be a devastating scourge.

There has not been wanting, however, a little body of anti-vaccinationists who have had the assurance to fly in the face of experience, and confidently to stake their ignorant prejudice against scientific knowledge. One of the least intelligible crazes of the time has been the anti-vaccination craze. It is difficult to understand how such a movement has ever been able to command fanatical adherents: yet such has been the case. One can imagine an unusually sceptical person entertaining doubts as to the efficacy of vaccination; but the state of mind accompanying such doubt one would expect to be the opposite of violent. In point of fact, however, the anti-vaccinationists, whenever three or four of them have gathered together, have succeeded in working themselves up into a state of frenzied anatagonism to the very mild oppression involved in compulsory vaccination. They have conjured up visions of loathsome diseases communicated by the vaccine virus: but these imaginary troubles gave only an additional fillip to their zeal. The real source of their ardor was that peculiar animosity aroused in the ignorant and conceited when they pit themselves against a doctrine established by patient research and stamped with the approval of the whole learned world. One sees precisely the same phenomenon in the case of the circle-squarers, the perpetual-motion men, and the believers in the flatness of the earth. A society for the propagation of the latter doctrine was in quite active existence not many years ago in England, and may still, for aught we know, be inflaming the minds of its proselytes with burning indignation against mathematicians, astronomers, geographers, and all that tribe.

It is not entirely to be regretted that the anti-vaccination craze reached in Gloucester a degree of strength which led to practical recognition of it in the town legislation. The result of embodying the doctrine in practice will do more to stamp it out, the world over, than could be accomplished in any other way. Of course, it is lamentable that this result should be reached at so great a sacrifice of human life; but, as we have said, the sacrifice is not in vain. The state of things in Gloucester was thus described in a recent cable despatch:—

The situation in Gloucester, where virulent small-pox is raging, is so serious that the Government is likely to take charge. Up to March 28 there were 700 cases, and since then there has been an increase of 50 weekly. The percentage of deaths is 25, and the town is in a state of panic. The Dean of Gloucester has issued an appeal for assistance, all race meetings, etc., have been cancelled, and all railway and holiday arrangements have been abandoned. The town is generally avoided, and other towns are instituting quarantine against Gloucester.

The situation is due to the anti-vaccination views of the local Council, and now the citizens including those who were violently opposed to vaccination,are rushing in thousands to be vaccinated.

In one of his magnificent "Lay Sermons," Professor Huxley says that Nature's discipline is not even a word and a blow and the blow first; it is a blow without the word. The anti-vaccinationists have been punished for refusing to profit by a discipline much more merciful than that of Nature. Science and human experience have given them the word; and Nature had given them the blow after they had refused to heed the word. Having had both the word and the blow, let us hope that they will profit by the double discipline.

## RELATIONS OF MEDICAL EXAMINING BOARDS TO THE STATE; TO THE SCHOOLS AND TO EACH OTHER.*

Dr. William Warren Potter, of Buffalo, said there were three conditions in medical educational reform on which all progressive physicians could agree—namely, first, there must be a better standard of preliminaries for entrance to the study of medicine; second, that four years is little time enough for medical collegiate training; and, third, that separate examination by a state board of examiners, none of whom is a teacher in a medical college, is a prerequisite for license to practise medicine. It is understood that such examination can be accorded only to a candidate presenting a diploma from a legally registered school.

He further stated that a high school course ought to represent a minimum of academic acquirements, and that an entrance examination should be provided by the state for those not presenting a high school diploma or its equivalent.

He did not favor a National Examining Board as has been proposed, but instead thought all the states should be encouraged to establish a common minimum level of requirements, below which a physician should not be permitted to practise; then a state license would possess equal value in all the states.

In regard to reciprocity of licensure, Dr. Potter thought it pertinent for those states having equal standards in all respects to agree to this exchange of interstate courtesy by official indorsement of licenses, but that other questions were of greater moment just now than reciprocity. Until all standards were equalized and the lowest carried up to the level of the highest, reciprocity would be manifestly unfair.

He urged that the states employ in their medical public offices none but licensed physicians. This, he affirmed, would tend to stimulate a pride in the state license, and strengthen the hands of the boards.

He denied that there was antagonism between the schools and the boards, as had been asserted. He said that both were working on parallel lines to accomplish the same purpose, that there could not possibly be any conflict between them and that they were not enemies but friends.

The medical journals of standing from one end of the country to the other, he affirmed, were rendering great aid to the cause of reform in medical education, and the times were propitious.

He concluded by urging united effort by the friends of medical education saying that "the reproach cast upon us through a refusal to recognize our diplomas in Europe cannot be overcome until we rise in our might and wage a relentless war against ignorance, that shall not cease until an American State license is recognized as a passport to good professional standing in every civilized country in the world."

*Abstract of President's address to the National Confederation of State Medical Examining and Licensing Boards at the sixth conference of this body held at Atlanta, May 4, 1896.

"Pa, what is a diplomat?" "A diplomat, my son, is a liar who doesn't get found out."—*Puck.*

## FREQUENT DEPENDENCE OF INSOMNIA, MENTAL DEPRESSION AND OTHER NEURASTHENIC SYMPTOMS UPON DISEASE OF THE GASTRO-INTESTINAL TRACT. *

The writer pointed out that the symptoms named results admittedly from the graver forms of disease of the alimentary canal, such as cancer, ulcer, gastric catarrh, gastric dilatation, etc., in consequence of the lowered nutrition which these affections induce, from a starvation of the nerve centers through impoverishment of the blood, or from a poisoning primarily of the blood and secondarily of all the tissues by the products of fermentation, putrefaction and suboxidation. He showed that while cancer and ulcer of the stomach are more generally recognized at a comparatively early stage on account of the pain and vomiting which characterize them, gastric catarrh, gastric atony and dilatation of the stomach are more often allowed to progress to an advanced and comparatively hopeless stage before properly diagnosticated and placed under appropriate treatment. Hyperacidity or that form of gastric derangement in which an excess of hydrochloric acid is secreted he referred to somewhat at length because it is exceedingly common, accompanied nearly always by severe neurasthenic symptoms, including especially insomnia, etc., and yet being only demonstrable by the tube after a test meal, is very generally overlooked. The writer dwelt especially upon the almost constant association of hyperacidity with constipation and suggested as an explanation of the connection, that the superacid contents of the stomach upon passing into the bowel, inhibit or greatly diminish the activity of the intestinal ferments, which require an alkaline or at least a neutral medium, and that besides this serious interference with intestinal digestion, the excessive acidity may set up irregular or spastic contractions of portions of the gut. He had felt these contracted portions of intestines in such cases and considers the constipation thus produced an important link in the chain of causes which result in autointoxication.

*Abstract of paper by Boardman Reed, M.D., Atlantic City, N. J., before the Section on Practice of Medicine, American Medical Association, May, 1896.

# SOCIETY REPORTS.

## ALLEGHENY COUNTY MEDICAL SOCIETY.

*March 17, 1896.*

### TREATMENT OF STRANGULATED INGUINAL HERNIA.

[See page 586.]

DISCUSSION.

DR. J. B. CROMBIE: I would like to make one criticism of Dr. Stewart's paper, and that is in regard to taxis. I do not think any taxis should be made after the diagnosis of strangulated hernia has been made, unless it is done under an anæsthetic. I think more pain will be caused by attempting to reduce the hernia without an anæsthetic, and more damage will be caused, and that there is more danger than is occasioned by an operation. I think a great many surgeons agree with me on this point.

DR. EUGENE WASDIN: I wish the reader had given a little more acknowledgment to American surgeons. We are always so prone to talk about the Italians, and the Germans, and other nationalities, that we often fail to give proper credit to our own worthy and deserving countrymen. I am of the opinion that one of our countrymen was just a little ahead of the Italian surgeon, Bassini, in performing the operation discussed by Dr. Stewart this evening. I refer to Dr. Halsted, of Johns

Hopkins University. Dr. Halsted's operation differs but slightly from that of Dr. Bassini, except, perhaps, that he lays more stress on the entire obliteration of the internal abdominal ring. I do not think Dr. Stewart touched particularly on this point. The internal ring must be absolutely obliterated. Dr. Halsted was working along the same lines at the same time, and I think he should receive equal credit with Dr. Bassini. Of course there are some minor differences between the two operations. Dr. Halsted does not take the cord and place it between the muscular layers. He gives several reasons for not doing so. The cord is too bulky and the union is not so good. He places the cord immediately under the skin. I have heard his lectures on this subject and have seen him operate. He places the cord immediately under the skin and above the old internal ring. This point he insists upon. His plan of procedure has yielded most excellent results in my own hands.

I might say with reference to the double hernia which Dr. Stewart mentions, that I have had a similar case, with the exception that there was no strangulation. There was a direct and an oblique inguinal hernia on the same side, and on the other side there was an oblique inguinal hernia. I never saw a case of double hernia in which one was strangulated and one not.

Dr. J. J. Buchanan: I think that it is time that this subject received proper discussion, for we have been going on, year after year, without paying much attention to this most important matter. Of course, in large communities, such as this one, correct diagnoses are generally made, but I am sorry to say that, in my experience, there have been a number of cases in which patients have died from hernial strangulation, and where the diagnoses had not been made. The protrusions were generally small and the physician or surgeon in attendance failed to discover them.

In many cases of hernia the diagnosis of internal strangulation was made and nothing was done until the patient was practically moribund, because an operation was considered so grave that it was put off until it was too late. In view of these facts, I think the subject of strangulated inguinal hernia a very important one, and the remarks of the reader of the paper very timely.

I believe it is generally considered that strangulated herniæ in infants are very rare, and indeed there are surgeons of immense experience who have never observed a case. It has been my fortune to see one infant die of strangulated hernia, the parents refusing to permit an operation. This case, of course, convinced me of the fact that children do have strangulated hernia. I operated on a baby sent me by Dr. O'Brien, where there was a double hernia, strangulated on one side. The condition of the bowel fully justified the operation. The child recovered, but I may say that during its recovery it got an incarcerated hernia on the other side, but this was reduced without operation.

There is one point that was brought up by the gentleman who preceded me; that is, the difference between the Bassini and the Halsted operation. It seems to me, although the operations have an apparent similarity, that they are entirely different from each other. The placing of the cord between the two layers of the abdominal muscles in the Bassini operation practically makes a new canal, whereas the operation of Halsted brings the cord directly through the muscular layers at one point, and does away with the canal entirely. It will thus be seen that the principles of the two operations are entirely different. Personally, I favor the Halsted operation, because it seems to me that when the layers of sutures are applied as snugly as they should be in the Bassini operation, there is a good deal of pressure exerted on the spermatic cord. But Halsted brings the spermatic cord directly through the muscular layers above the internal ring, and the internal oblique and transversalis are sutured to Poupart's ligament. I have also added another layer of sutures in the tendon of the external oblique. I think that two layers of sutures are much better than one. It makes a very much better approximation of the parts, and strengthens them. I think the time will come when we will rarely have any cases of strangulated hernia, for the reason that all herniæ will be formally operated upon for the radical cure, and strangulation will thus be prevented.

Dr. W. H. Daly: Dr. Stewart's paper leaves very little to be said in regard to the surgical treatment of strangulated hernia; I merely rise to emphasize what Dr. Buchanan has said.

It has been my custom for a number of years to advise a curative operation in all cases of hernia which have fallen under my observation, and not waiting for the evil of strangulation. The great advances which have been made during recent years in abdominal surgery warrant such operation as a safe one, and I consider it my duty to advise an early operation and not allow the patient to wait until life is in danger by strangulation. Now with reference to the operation after strangulation: Of course the surgeon always is inclined to favor an early operation in case of strangulated hernia; but, on the other hand, during the past several years I have seen many cases where placing the patient in a position with the buttocks elevated on an incline plane, and the administration of a large dose of morphine hypodermically, resulted in a reduction of the hernia by simple gravitation, and I therefore argue that it is not wise to decide on operation too hastily during strangulation until the gravity method of reduction has failed. That the chances of recovery for the patient from an operation for hernia are much enhanced when the factors of strangulation, vomiting, pain and prostra-

tion are not present should need no argument since, when an operation must be done as a *dernier ressort* the conditions are obviously far more unfavorable than when the patient is going about and can select his own time and enable the surgeon to prepare him for a curative operation.

DR. HOFFMAN: I would say in regard to strangulated hernia in infants that I believe the cases are more common than is generally recognized, and are generally treated for some disease which presents some similar symptoms, some gastric disturbance or supposed cholera infantum, and the abdomen of the child is not even examined. Medicines are given to allay the vomiting, while a hernia is never looked for.

DR. STEWART, closing the discussion: In answer to the criticism of Dr. Crombie I must certainly adhere to the position I have taken, that taxis should be used in all cases when first seen and should not be used when the patient is under an anæsthetic and ready for an operation. If taxis is used when the patient is first seen it will often be successful and the danger of strangulation averted, thus allowing the patient to select a more judicious time for the radical cure of his hernia.

I am glad that Dr. Wasdin called attention to the necessity of complete closure of the upper part of the inguinal canal, which I did not emphasize. I think it still more important, however, that there should be a complete closure of the lower part of the canal, for at this point there is the greatest strain and the greatest liability to the re-formation of the hernia.

In regard to the priority of the operation between Dr. Halsted and Dr. Bassini it may be said that Dr. Bassini waited until he had over two hundred cases of operation before he published his method. How many cases Dr. Halsted had at this time I do not know. I agree with what Dr. Buchanan has said regarding the frequency of strangulated hernia in infants. It is a condition which is often overlooked. Recently I was called on two successive evenings to attend two infants who were suffering from strangulated hernia.

Dr. Daly advocates the employment of elevation of buttocks and morphine where taxis fails instead of resorting to immediate operation, and at the same time rather contradicts himself by advocating operation in all cases of non-strangulated hernia, for if an operation is advisable in non-strangulated hernia it is much more so in strangulated hernia even in the early stage of the case when the patient is in good condition, and is imperatively necessary if the strangulation has existed for some time.

DR. W. H. DALY: I would like to ask Dr. Stewart if he wishes us to understand it to be his opinion that the patient's chances for recovery are as good if operated upon after strangulation, vomiting, pain, prostration and excitement, as they would be without these factors present; as, for instance an operation before strangulation takes place in order to prevent the accident of strangulation. I do not think they are.

DR. STEWART: In answer to Dr. Daly I would say that a patient is not in as good a condition for operation during any period of a strangulation as he would be when the hernia is not strangulated. I do say, however, that it is improper treatment to delay herniotomy when taxis fails, as the earlier a case is operated on, the more nearly it approaches to the condition in which we find a non-strangulated hernia, and the less the risk. Delaying the operation seriously adds to its gravity without offering a commensurate benefit in the chance of spontaneous reduction.

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### GASTROSTOMY.

DR. R. W. STEWART: P. B., aged 49. On admission to the hospital, on December 30, 1895, this patient gave a history of having, eight weeks previously, fallen into a vat containing glue and an acid, the nature of which he could not specify. As a result he received superficial burns of the skin and swallowed part of the mixture. This was followed by dysphagia, and subsequently by stricture of the œsophagus. At the time of his admission to the hospital, he was much emaciated and swallowing was impossible, except such liquids as water and milk, and they had to be sipped slowly or else they would regurgitate into the mouth. The œsophagus was dilated above the stricture, forming a pouch from which food that had been taken in the evening would be regurgitated in the following morning.

Persistent attempts to pass œsophageal bougies of various sizes failed; and, as a few more days of starvation would exhaust the patient, I decided to perform gastrostomy, which was accordingly done on the following day.

The operation was performed at one sitting, the incision was made parallel to, and immediately below, the costal cartilages on the left side, the peritoneal opening being close to the rectus muscle. The abdominal incision extended obliquely upward so that the peritoneal incision lay directly under the costal border. The stomach was brought out into the wound, and a point near the lesser curvature was sutured to the parietal peritoneum by a series of interrupted sutures, which was reinforced by a continuous suture.

The stomach was opened so that a finger could be easily inserted. An attempt was made to insert the finger into the cardiac orifice of the œsophagus, but failed to reach that point. A urethral bougie was then passed into the œsophagus, but I was unable to pass it or smaller ones which were tried, through the stricture. The patient was then sent to bed and a pint of beef tea administered through the gastric fistula. The subsequent

history of the case presents nothing unusual. The patient did not suffer from shock, and in a few days was able to be around. After the operation his ability to swallow improved somewhat, and he is now able to swallow milk and beef tea better than before the operation, but such things as oatmeal or corn starch will not pass.

It may be added that repeated attempts to pass bougies subsequent to the operation have failed, and the patient, who has gained much in weight and strength, sustains himself by injecting his food in a liquid form through the gastric fistula. Since the operation the patient has never at any time suffered from extravasation of the stomach contents.

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### A CASE OF GASTROPTOSIS WITH HYPERCHLORHYDRIA.

DR. FRANK H. MURDOCH: I wish to report the following case which came under my notice last November. Mr. F., aged 23, had always enjoyed good health until within four months past, when he began to have trouble with his stomach, the result, as he believed, of eating strawberries. When I saw him he complained of pain in the gastric region (accompanied with belching) coming on about three hours after meals, and which was relieved by eating. He had been obliged to give up work, felt weak and despondent, had lost 10 pounds in weight, slept badly and had bloating of the feet and ankles, coming on in the afternoon. His tongue was clean, his appetite was good, his chest organs intact, the urine contained neither sugar nor albumin, his knee jerks were present, his right kidney could not be palpated, his bowels were moved only when he used water injections. The splashing sound could be heard two and a half inches below the umbilicus when the patient was in the recumbent posture; and on standing after drinking two glasses of water, the line of stomach dullness extended three and a half inches below the navel. The upper border of the stomach seemed to lie midway between the navel and the ensiform cartilage. At that time I advised him to have his stomach washed out occasionally, to live principally on albuminous food, and gave him strychnine to take before meals. Being absent from home I did not see him again till February 13th, soon after my return to the city. I found his general condition somewhat improved. He had less distress in the gastric region, his bowels were moving regularly, and he had been able to work part of the time since January 1st, although his feet were still swelling, and he complained of feeling weak and of being easily tired. The splashing sound was present as on former examinations, and this could be heard in the morning fasting, showing that the stomach did not entirely empty itself even during the night. An hour after Ewald's test-breakfast, the gastric juice contained hydrochloric acid in excess, being 84 with a total acidity of 144.

To determine the exact size and location of the stomach, instead of distending the organ with air, as advised by Runeberg, it was illuminated by means of Einhorn's gastro-diaphane, which consists of a small incandescent electric lamp attached to the end of a flexible stomach tube. The patient drinks a glass or two of water, the lamp is introduced into the stomach and in a dark room the light is turned on. The position and size of the organ is indicated by the red reflex seen through the abdominal wall. In this case the translumi-nated zone was carefully outlined and the abdomen, as suggested by Dr. Buchanan, photographed. The stomach reaches well down to the pubis and lies in an almost vertical position from the pylorus, being displaced downwards and to the left. According to Ewald this condition may be due either to traction or pressure, or it may be congenital.

Here then is a patient suffering from gastroptosis and hyperchlorhydria, the acidity of the gastric juice being about three times more than normal, two conditions which would account for all his symptoms; namely, weakness, lassitude, inability to digest starchy food, with pain in the gastric region three hours after meals, sleeplessness, swelling of the feet and ankles and constipation.

The treatment of the case consisted in a diet from which starchy food, excepting stale bread, was excluded, an abdominal bandage to raise the stomach and prevent dragging, faradization applied directly to the mucous membrane of the stomach by means of Einhorn's deglutable electrode to tone up the abdominal muscles and improve the motor power of the stomach, and strychnine for its general tonic effect. Under this treatment the patient has steadily gained in strength and weight, the distress in the stomach has disappeared as well as the bloating of the feet and ankles, and at present he is able to attend to his work as usual. The acidity of the gastric juice has been reduced from 144 to 104, and the hydrochloric acid from 84 to 40; and, while the stomach will never of course resume its normal position, the patient may, by being careful about his diet and regular in his habits, nevertheless go through life very comfortably.

DR. CHRISTY:—I would like to ask the early history of this case, and if it is known how this condition came about.

DR. MURDOCH:—I do not know the cause of this condition; possibly it may have been congenital, some of these cases are. If the cause was not congenital, I have no idea what brought it about.

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### REPORT OF A CASE OF PERTUSSIS WITH UNUSUAL COMPLICATIONS.

DR. W. T. BURLEIGH:—Patient T. D. B., male, aged seven weeks. The first five weeks were uneventful, and nothing occurred out of the ordinary routine. During this period he was at different times placed on the following

medicines: ammonium bromide, gr. ij, every two hours; tincture of belladonna, m. ¾, every two hours, and bromoform, one drop every two hours, without much apparent benefit. At the beginning of the sixth week, while taking the bromoform, during a paroxysm of cough, he suddenly ceased breathing and was with great difficulty resuscitated.

There was intense rigidity of the chest and abdominal muscles, and probably also of the laryngeal muscles, and great lividity. None of the other muscles were affected.

This occurred at half-hour and hourly intervals throughout that night. Hypodermic injections of whiskey, artificial respiration, warmth to the surface, and compound spirits of ether were employed. My friend, Dr. Arnholt, saw the case with me that night.

This condition continued the next five days, except that the paroxysms of cough grew less and finally ceased, and the cessation of breathing occurred without warning, so that it was necessary for the patient to be under constant observation night and day. For three days of this period the patient was unable to swallow, the attempt producing the cessation of respiration.

For four days I did not have my clothes off, and was unable to leave the house unless another physician took my place.

During the greater part of the period the patient took atropine gr., 1-250 in twenty-four hours.

The most successful method of resuscitation was mouth to mouth inflation of the lungs.

During some of the attacks, five minutes by the watch elapsed before the breathing was re-established.

The method of treatment which I have not yet mentioned, and which I believe saved the patient's life, was the inhalation of oxygen, suggested to me by my friend, Dr. Crombie, on the second day. Oxygen is now on the market in a portable and practical apparatus for inhalation, and is, I believe, of great service in diseases where cyanosis is a prominent symptom.

The patient has now passed over two months of his sickness, without any other complications save an abscess of the neck, and is on a fair road to recovery.

DR. W. S. HUSELTON:—I would like to ask the reader of the paper if he considered that the critical condition of the patient was brought about by the bromoform. This is my understanding of the case as presented in the paper.

DR. BURLEIGH:—I did not intend to give that impression, as I did not consider bromoform the cause. I look upon bromoform very much as I do upon chloroform, or a narcotic. I administer it for about twenty-four or perhaps forty-eight hours, and if I do not produce the desired effects I stop giving it. I really do not think the condition was due to the bromoform.

# PERISCOPE.

## NEWS AND MISCELLANY.

**Dr. S. H. Durgin, Chairman of the Boston Board of Health,** is authority for the statement that the mortality among school children in Boston is larger than in any other city in this country or in foreign countries. This is due largely, he says, to the unsanitary surroundings of the children in school. The rooms are unwashed and full of dust and dirt, the temperature in cold weather is kept abnormally high, and the air the children are compelled to breath is abominable. This excessive mortality in Boston is despite a medical supervision of the schools which is claimed to be unique. A number of physicians are employed at a small annual salary. They visit the schools each morning, and are given a list of all the pupils who complain of illness, or who appear to the teachers to be ill. They examine the children, and send home those unfit to be in school with a report of the disease with which they are afflicted. During the first year of the operation of this plan 14,666 children were examined. Of these 9,188 were found to be sick, and 1,7 5 of that number were ill enough to be sent home. There were found 437 cases of infectious diseases, including 70 cases of diphtheria, 110 cases of scarlet fever, and as many of measles. There were discovered also many cases of diseases, such as impaired hearing and sight, not suspected by the children, parents or teachers.

**Italy proposes to take the sale of quinine** out of the hands of the druggists and to make it a Government monopoly. Druggists sell it at the rate of from $50 to $100 a pound, while the Government gets it for the army at $5 a pound. It will be sold in sealed tubes to prevent adulteration, in doses of one gramme, at a cost of 3 and 4 cents.

"Embellishment," said Uncle Eben, "am all right 'nough in its way. But 'tain't de curlycues in de handwritin' dat satisfies de gemman at de bank when er check comes 'long."

**During a discussion of anglomania** in the United States in general, and in New York in particular, overheard in a fashionable restaurant, opinion seemed about evenly divided between those who thought the disease was spreading and those who believed it was

growing less pronounced and virulent among the class who most keenly enjoy suffering from it. One man said what has a good deal of truth in it:

"The most asinine form it takes is the drinking of champagne which does not suit one's taste, merely because the brand has vogue in England. Now, I know no fewer than a dozen young men in a club on the avenue, who have adopted a certain brand for no other reason than it ranks high in the best London clubs. It is intensely dry, so dry, in fact, as to impress one not used to such wines as being an aerated kind of highly rectified alcohol, for its absolute lack of any sweetness whatever gives the American palate that impression.

"A good many Englishmen prefer these ultra dry brands, and when they can find them will pay a little more than they will for other vintages or brands. Their vogue among a certain set of men here, is simply because they wish to do as their models do. But the great majority of English champagne drinkers do not prefer the tasteless brands, and the wines that are most popular with us have the same patronage in London. And if such was not the case, what has that to do with it any how? The American public does not drink heavy brews and discard its sparkling lager beers because John Bull prefers the weightier and more heady beverage, nor are we as a nation likely to discard the fluid extract of Kentucky for the spirit of Scotland, simply because the Englishmen prefer their stimulants in the latter form. Therefore, I think I am right in saying that the small set of men in New York who affect the intensely dry champagnes that head the price lists in the English wine markets, do it merely because they are consistent anglomaniacs and must stick to their guns all along the line. Such wines will never become popular."—*New York Mail and Express.*

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**The Annual Meeting of the Alumni** of the University of Buffalo Medical Department was held on Commencement Day, Tuesday May 5th, 1896. The morning was devoted to a business session, and in the afternoon the President of the Association delivered an address, which was followed by a series of papers upon scientific topics.

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**The Fourth Triennial Prize of Four Hundred Dollars,** under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on

"THE ETIOLOGY AND PATHOLOGY OF DISEASES OF THE ENDOMETRIUM, INCLUDING THE SEPTIC INFLAMMATIONS OF THE PUERPERIUM."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with obstetrics, or the diseases of women, or the diseases of children;" and that "the Trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said Trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, must be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., before January 1, 1898, addressed to Barton Cooke Hirst, M.D., Chairman of the William F. Jenks Prize Committee.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

JAMES V. INGHAM,
*May 1, 1896.* *Secretary of the Trustees.*

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### Medical Conventions, 1896.

Physicians and others attending the various Medical Conventions for 1896 should bear in mind that the B. & O. offers special inducements to conventions of this kind. The scenic attractions of this route are unsurpassed in this country. All B. & O. trains between the east and west run via Washington, and sufficient time limit is given on tickets to allow a stop-over at the National Capital.

The meeting of the Amer. Assoc. Genito-Urin. Sur. will be held at Atlantic City, first week in June.

The meeting of the Amer. Gynecol. Soc., in New York, May 26.

The meeting of the Amer. Laryngol. Asso., in Pittsburg, early in May.

The meeting of the Asso. Mil. Sur. of U. S., in Phila., May 12, 13 and 14.

The meeting of the Climato. Asso., Lakewood, N. J., May 12 and 13.

For rates and other information, address Chas. O. Scull, General Passenger Agent, Baltimore, Md., or L. S. Allen, A. G. P. A., Chicago, Ill.